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STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF MEDICAL PRACTICE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: WWW.DPR.DELAWARE.GOV

Verification of Physician Assistant License

Use a separate form for each state in which you have ever been licensed to practice as a physician assistant. Forward to the other state or Licensing Authority for their completion.

Name of Licensing Authority: _____	Applicant's Name: _____
_____	Address: _____
Address: _____	City/State/Zip: _____
City/State/Zip: _____	Telephone Number: _____

This section is to be completed by the applicant. **Don't forget to sign the form.**	Last Name: _____ First Name: _____ SSN: _____ License Number:_____ DOB: _____ Name if Different from Above: _____ I am applying for licensure as a Physician Assistant in the State of Delaware. Before my application can be reviewed, verification of my license in good standing is required. I am authorizing the release of the information requested on this form to be sent to the State of Delaware Board of Medical Practice. Signature: _____ Date: _____
To be completed by the Licensing Authority	Our records indicate that _____ was licensed in the State/Province/ (Type or print individual's name) Jurisdiction of _____, on _____ and was (MM/DD/YY) issued License Number _____ . Expiration Date: _____ (MM/DD/YY) Has any discipline activity taken place regarding this licensee? Yes _____ No _____ **If any action has been taken, please enclose a certified copy of the Board Order when returning this license verification to the Delaware Board of Medical Practice.**
Certification *****AFFIX** **OFFICIAL** **SEAL HERE**	Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. Name:_____ Signature:_____ Title:_____ Date of Signature: _____ Tel: _____ Fax: _____ E-mail: _____

*****RETURN COMPLETED FORM WITH <u>SEAL AFFIXED</u> TO THE BOARD ADDRESS ABOVE. THANK YOU.**